PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Public Health Council was held on Wednesday, October 8, 2008, 9:00 a.m., at the Department of Public Health, 250 Washington St., Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Mr. Harold Cox, Dr. John Cunningham, Dr. Muriel Gillick, Mr. Paul J. Lanzikos, Ms. Lucilia Prates Ramos, and Mr. José Rafael Rivera, Dr. Meredith Rosenthal, Mr. Albert Sherman (arrived at 9:35 a.m.), Dr. Michael Wong, and Dr. Alan C. Woodward. Dr. Michèle David, Ms. Helen Caulton-Harris, Mr. Denis Leary, and Dr. Barry S. Zuckerman were absent. Also in attendance was Attorney Donna Levin, DPH General Counsel.

Chair Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance.

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF AUGUST 13, 2008:

A record of the Public Health Council Meeting of August 13, 2008 was presented to the Public Health Council for approval. Dr. Alan Woodward, Council Member, moved approval. After consideration, upon motion made and duly seconded, it was voted unanimously to approve the August 13, 2008 record as presented. The record was distributed to the members prior to the meeting for review.

Council Member Mr. Paul Lanzikos had concerns about the August 13 Minutes stating clearly enough that the Northeast Hospital Corporation/Beverly Hospital project that was approved at that meeting "provide in writing" to patients that free transportation is available for patients with hardship to get to Northeast Hospital Corp./Beverly Hospital's MRI facilities. Attorney Donna Levin, General Counsel for DPH, said the statement in the minutes is adequate. However, As requested by Chair Auerbach, Determination of Need Program Staff agreed to send the applicant an addendum to the Decision Letter clarifying to the applicant that they agreed at the August 13, 2008 PHC meeting to provide "in writing" information about free transportation availability to hardship patients to their MRI facilities so patients can access the service themselves.

PROJECT APPLICATION NO. 4-3B60 OF MOUNT AUBURN HOSPITAL:

Council Member Dr. Michael Wong recused himself from discussion and voting on this application.

Mr. Jere Page, Senior Program Analyst, Determination of Need Program, presented the application to the Council. He said, "...Mount Auburn Hospital is before the Council today, seeking approval for substantial new construction and renovation on the Hospital's campus in Cambridge. The project involves the construction of a new six-story wing to expand medical/surgical beds from 137 to 160, and new construction/renovation to expand critical care services from 18 beds to 20 beds, as well as add two new operating rooms. The new construction and renovation are intended to address the need for improved medical/surgical and critical care capacity at Mount Auburn Hospital, as well as improvements in some ancillary areas, such as radiology, cardiology, surgery, nuclear medicine, and administrative space. It is expected that the entire project will be completed by May of 2010. This project is intended to correct a number of functional and physical inadequacies inherent in the Hospital's existing space, that hinder its ability to meet the needs of its growing volume of medical/surgical intensive care and surgical patients, as well as accommodate changes in medical equipment and technology needed to provide state-of-the-art services. Mount Auburn believes that the new and expanded services are better designed to optimize patients to have access to ensure operational efficiency, as well as ensure important adjacencies for clinical support."

Mr. Page noted further, "The recommended maximum capital expenditure is 45 million dollars, which will be financed through an equity contribution of 21 million dollars from the hospital's available funds. The remaining MCE of 24 million dollars is being funded by tax exempt bonds issued by the Massachusetts Health and Educational Facilities Authority at a fixed interest rate of 5.4% for a 30 year term. The funding for community initiatives associated with this project is 2.25 million dollars over a period not to exceed seven years. This funding will be used to support community-based projects that promote wellness and prevent injury and disease, based on priorities identified through community health assessments, and community-based planning. These will be conducted in coordination with the appropriate Department Regional Centers for Healthy Communities."

In conclusion, he said, "Staff is recommending approval of this project with the five conditions listed on pages 12 and 13 of the staff summary, and please note also that Mount Auburn is represented today by its President Jeannette Clough, and its Chief Operating Officer Nick Dileso, and they are prepared to address the Council, and of course we would be happy to answer any questions."

Discussion followed by the Council. Council Member José Rafael Rivera stated, "It is very encouraging for me to see the Community Health Initiative with a workforce development initiative for Community Health Workers and I hope to see more of that because it is a great way to address health disparities and cultural competency among some providers, so very encouraging to see." Council Member Dr. Alan Woodward inquired about the distribution of beds in the rooms of the hospital. Mr. Page clarified: Currently, they have 106 private rooms, 19 two-bed rooms and 13 four-bed rooms. When the project is completed, they will have 174 private rooms, and 22 two-bed rooms, and no four bed rooms."

Ms. Jeannette Clough, President of Mount Auburn Hospital also clarified, "Our goal is to continue to move towards an all private room facility for all the reasons that, probably, people are familiar with, but the other important distinction here is that, currently, all of our four-bed rooms are in Medical/Surgical. The singles are in OB and Critical Care and Geriatric Psychology, so the chances, if you are a medical/surgical patient, which is the bulk of our population, going into a four-bed room now are quite high. Whereas, as we move to the new building, there will be a lot more private rooms for medical/surgical patients." Dr. Woodward asked about the step-down unit and Ms. Clough said they have a 14-bed step-down unit to get patients out of critical care. Dr. Woodward further inquired about the building being green (though it is not a requirement for this project); and further about the hospital's ability to complete the project as scheduled with the economic climate as it is. Mr. Nick Dileso, Chief Operating Officer for Mount Auburn replied that the building was a Green Guide Pilot Project before LEED came up with their green goals. Ms. Clough said it would be equivalent to a LEED Silver and further that their development effort raised about a quarter of the amount of the building cost, to finish the building without needing to borrow. "We have had the fortunate situation of being able to generate profits and put them back into the cost for the facility", she said.

Discussion continued and Ms. Gillick inquired about their plans to alleviate any traffic jams resulting from the construction of the project. Ms. Clough said they had good rapport with abutting neighbors and not much of a traffic problem because they do more inpatient than outpatient services. Chair Auerbach said, "...As of January 1, 2009, the Department will be banning the use of diversion for emergency rooms due to work that Dr. Woodward and I have been involved in with that task force, and one of the reasons that we were concerned about this issue is, we are hearing of significant back-ups in emergency departments, lengthy stays and, in some cases, boarding. Has this been a problem at Mount Auburn, and are you anticipating that the construction will affect that?"

Ms. Clough replied in part, "...Dr. Woodward's question about the critical care beds is significant because, often, monitored beds are the reason for the inability to get people into a bed quickly. This project will absolutely help the number of monitored beds that we have in the facility, and the critical care bed increase will certainly alleviate the potential for a diversion. We have also instituted a number of other changes in the emergency room, but I think this project will certainly enhance our ability to flow patients through from the emergency room as quickly as possible. Just to give you a sense, last month our diversion hours were six hours in the month. Last year, the numbers were in the 30 to 40 hours a month – our total hours for last year were 246 hours and this year it will be less...Mr. Nick Dileso added that the four bed rooms are an obstacle to getting patients into a room because they are single sex rooms and also anyone with an infection cannot go into a 4-bed room so alleviating the 4-bed rooms will make a substantial difference in people getting into a room..."

Council Member Dr. Alan Woodward moved for approval of the project. After consideration about motion made and duly seconded, it was voted unanimously [Dr. Michael Wong recused; Mr. Albert Sherman not present to vote] to approve **Project Application No. 4-3B60 of Mount Auburn Hospital, Cambridge**, based on staff findings, with a maximum capital expenditure of $45,171,908 (July 2008 dollars) and first year incremental operating costs of $8,658,091 (July 2008 dollars). A staff summary is attached and made a part of this record as **Exhibit No.14, 913.** As approved, this application provides for construction of a new wing to expand medical/surgical beds (from 137 beds to 160 beds), and new construction/renovation to expand critical care services (from 18 beds to 20 beds), add two new operating rooms (ORs) and improve ancillary areas such as radiology, cardiology, surgery, nuclear medicine and administrative space. This Determination is subject to the following conditions:

1. Mount Auburn shall accept the maximum capital expenditure of $45,171,908 (July 2008 dollars) as the final cost figure except for those increases allowed pursuant to 105 CMR 100.751 and 100.752.

2. Mount Auburn shall contribute 46.5% in equity ($21,007,454 in 2008 dollars) to the final approved MCE.

3. The total gross square feet (GSF) for this project shall be a total of 102,645 GSF: 79,859 GSF for new construction and 22,786 GSF for renovation to expand medical/surgical and critical capacity, as well as improve some ancillary areas including radiology, cardiology, surgery, nuclear medicine and administrative space.

4. Mount Auburn shall provide a total of $2,258,595 (2008 dollars) over a period not to exceed seven years to fund the community health service

initiatives described previously in Section H: Community Health Initiatives.

5. With regard to its interpreter service, Mount Auburn shall:

    - Provide information to patients on the availability of interpreter services at no cost to the patient.

    - Develop a plan for interpreter services enhancement at Mount Auburn Hospital addressing the above, which shall be submitted to the Office of Health Equity within 45 days after the approval of the project.

    - Submit an annual progress report to the Office of Health Equity 45 days after the close of each federal fiscal year.

    Staff's recommendation was based on the following findings:

    1. Mount Auburn Hospital is proposing construction of a new six-story wing to expand medial/surgical beds (from 137 to 160 beds), and new construction/renovation to expand critical care services (from 18 beds to 20 beds) and add two new operating rooms (ORs). The new construction and renovation are intended to address the need for improved medical/surgical and critical care capacity, as well as improvements in some ancillary areas such as radiology, cardiology, surgery, nuclear medicine and administrative space.

    2. The Department found that the health planning process for the project was satisfactory.

    3. The Department found that proposed new construction and renovation is supported by current and projected utilization, as discussed under the Health Care Requirements factor of the staff summary.

    4. The Department found that the project, with adherence to a certain condition, meets the operational objectives factor of the DoN regulations.

    5. The Department found that the project, with adherence to a certain condition, meets the standards compliance factor of the DoN regulations.

6. The Department found that the recommended maximum capital expenditure of $45,171,908 (July 2008 dollars) was reasonable compared to similar, previously approved projects.

7. The Department found that the recommended operating costs of $8,658,091 (July 2008 dollars) are reasonable compared to similar, previously approved projects.

8. The Department found that the project is financially feasible and within the financial capability of the Applicant.

9. The Department found that the project meets the relative merit requirements of the DoN regulations.

10. The Department found that the proposed community health service initiatives, with adherence to a certain condition, are consistent with the DoN regulations.

PRESENTATION - "Fall Related Injuries and Deaths Among Older Adults":

Chair Auerbach made introductory remarks, "...The number of fall related injuries and deaths are a significant problem, both inside and outside of health care institutions. It is one that has, over the last few years in particular, received a great deal of attention, not only because of its significance in terms of quality of care and impact on patients, but also because of the significant costs that are associated with caring for these injuries..."

Dr. Holly Hackman, Epidemiologist, Office of Statistics and Evaluation, also made introductory remarks, "...For several years now, the Department has conducted surveillance of both fatal and non-fatal fall injuries as part of our General Injury Surveillance work. We have been monitoring increases in these injuries. As you may recall, in April of this year, the Department released the 2006 Death Data, which showed a marked one-year increase in the number of fatal falls in Massachusetts. This presentation is a follow-up to that finding, providing details on what we uncovered in investigating it, and also giving you the broader contextual look at the problem of falls, the longer term trends, the injuries, the types of injuries that are involved, the circumstances and places where these are occurring, as well as some insight into the non-fatal fall injuries. We are releasing today a comprehensive report

on falls among older adults, which will serve as a foundation for future surveillance and prevention activities."

Ms. Carrie Huisingh, Epidemiologist, Office of Statistics and Evaluation, addressed the Council. Some highlights from her presentation follow:

"Fall injuries are an enormous threat to the health and well being of older adults. In the United States and in Massachusetts, falls are the leading cause of injury death and disability. A recent report, produced by the Health Department, indicated that the fall death rate among older adults is increasing in Massachusetts. Also, fall prevention efforts and activities have been increasing at the national, state and local levels. One example is the 2005 Massachusetts Injury Prevention Plan, which identified falls among older adults as one of four priority areas."

"Falls can often lead to a downward spiral of health, resulting in nursing home placement and sometimes death. In addition, 80% of fall injuries that occur are in the 65 and older population, and our population is aging. The proportion of the Massachusetts population over 65 years of age is expected to increase from 13 ½ percent in 2000 to 20.9 percent in 2030."

"As our aging population increases in size, the number of fall injuries will substantially increase due to demographic changes, unless prevention strategies are effectively implemented."

"...Most importantly, falls represent a serious but often preventable public health problem. Traditionally, falls have been viewed as accidents, or as part of the normal aging process. In reality, falls are largely preventable. Similar to the prevention of chronic diseases, fall injuries can be prevented through the identification and reduction of well documented and modifiable risk factors."

"The data sources used to examine the burden of falls include the Death Certificate data, Statewide Inpatient Hospital Discharge, Outpatient Observation Stays, Emergency Department Discharge databases, the Behavioral Risk Factor Surveillance System or BRFSS, and national data are available through the Centers for Disease Control and Prevention, and the National Center for Health Statistics."

"In 2006, there were 340 deaths from a fall and a combined total of over 56,000 hospital stays and emergency department discharges associated with a non-fatal injury among Mass residents, ages 65 and older. This number does not include fall injuries treated somewhere other than an acute care hospital."

"On average, six fall deaths occur each week and, on an average day, there were over 150 hospital discharges associated with a fall injury. Among non-institutionalized older adults, or those living in the community, approximately one out of six reported a fall in the past three months. Of these, 29% reported that they were injured."

"From 2000 through 2005, Massachusetts age-adjusted rates of fall deaths remained substantially below the national rate. For the same six year period, the U.S. age-adjusted fall death rates increased 37% and 2005 is currently the latest year for which the U.S. death rate is available. During the same time period, the Massachusetts age-adjusted fall death rate increased 25%. Then, from 2005 to 2006, a 66% increase was noted. Since these represent age-adjusted rates, which control for differences in the age distribution of populations, from year to year and between Massachusetts and the United States, the increase in the rate is not entirely explained by an aging population."

Staff investigated the reasons for the increased fall injuries in the 2005 to 2006 in Massachusetts and found, "We concluded that the increase in the fall deaths from 2005 to 2006 was largely due to changes in the identification and classification of fall deaths at the Office of the State Medical Examiner (OCME). The CDC concurred with this assessment. However, despite this, we do not what to lose sight of that the fall deaths, over the longer time frame do appear to be increasing, both nationally and in Massachusetts, for reasons that neither we, nor the CDC fully understand…The department examined the longer term trend in non-fatal fall injuries and found that hospital stay rates increased 5% and Emergency Department rates increased 4%."

"Falls are more prevalent among older adults that are disabled and need help, obese, and older adults with less than a high school education. There were less prevalent among older adults who reported exercise versus no exercise in the past month."

Home was listed as the place of injury for almost 60% of fall deaths and 68% of the hospital stays. Nineteen percent of the falls occurred in a nursing home, and three percent of the falls occurred in a hospital."

In Massachusetts, the combined hospital charges for fall-related visits were four hundred seventy-one million in Fiscal Year 2006. Nationally, the total cost for fall-related injuries exceeded 19 billion in 2000, and are projected to reach 43.8 billion in 2020. The economic burden for these fall-related injuries underscores the need for effective interventions."

In conclusion, Ms. Huisingh, Epidemiologist, Office of Statistics and Evaluation, said, "Fall injuries are serious and an increasing public health problem, both in Massachusetts and nationally. While fall prevention activities have gained momentum in Massachusetts in recent years, the Massachusetts Department of Public Health Injury Surveillance Data indicates that there is a tremendous amount of work left to accomplish. Injury Surveillance Data can provide injury prevention practitioners and key leaders with the information to monitor the magnitude, the trends, risk factors and circumstances of these events, in order to efficiently and effectively target and evaluate outcomes of our prevention activities."

Discussion followed. Dr. Michael Wong, stated, "...Those are really quite astounding numbers and all. I think, for those of us who are in health care, this validates what we have been seeing in the hospitals and emergency rooms...Is there any way to capture information on whether or not these individuals had recently been hospitalized or had some kind of medical intervention through outpatient settings? The reason I ask is, there is this huge growing trend for many hospitals, to make sure that medications are filled on discharge, which may include duplicate drugs or duplicate prescriptions for medications that already exist and I know with my own patients, after being discharged from a hospital, they come and see me four weeks later with duplicate medications in their pill box, they have been actually taking double the dose of what they should be taking, which can include diuretics and medications for hypertension. I am wondering how much of this might actually be inadvertent iatrogenic postural hypertension and dizziness."

Dr. Hackman responded, “I think you have raised a valid next step for our surveillance activities, which is to start looking even deeper at the circumstances that are driving that low grade increase, and that actually is going to require a more longitudinal look at the hospital discharge data, to see how many of these falls are related to a readmission from a hospitalization stay within thirty days or sixty days prior. That can be done with our current discharge database, which is wonderful in this state, it has excellent injury data associated with it, known as the E-codes, or External Cause of Injury Codes…We don’t have systematic collection data going on in the state to see if there might have been a change in medication regimes. That would require hospital data abstraction and a documentation of such in the medical record by the clinicians…”

Dr. Wong asked further, “I wonder if there might be a way to pilot with some of the hospitals and clinics that have EMR already in place?” Dr. Hackman replied, “Absolutely, yes”. Dr. Alice Bonner, Executive Director, Massachusetts Long Term Care Foundation Association, Assistant Professor of UMass, noted, “The Health Care Quality and Cost Council has a new work group on transitions in care and that would be a perfect aspect of that pilot, would be to look, because we will be looking at medication reconciliation, as you mentioned, falls, trying to get at all the reasons why people wind up back in the hospital.”

Discussion continued. Mr. Harold Cox, Council Member asked about ice related falls. It was noted that level of information about the circumstances surrounding a fall is not available. It was noted that there is no seasonal fluctuation with falls and this may be due to the fact that most falls occur in the home. Mr. Josè Rafael Rivera asked if substance abuse, which is often invisible in the older population is considered. Dr. Hackman said they don’t have that data and said, “What that would require is medical abstraction or toxicology reports from the Medical Examiner’s office.” Chair Auerbach asked Dr. Hackman to comment on the trends relating to the increase in traumatic brain injury related hospitalizations and the decrease in terms of hip related hospitalizations. Dr. Hackman replied, “The decrease in the hip fractures is felt to be related to improvements in the management of osteoporosis. The increase in traumatic brain injuries related to falls is not nearly as clear to us, as to what is driving that. There is no comparable national data on this. The possibilities are increased diagnosis of these events through better neural imaging of fall injury, fall

injured elders or perhaps increasing medication, or changing medication regimes, anticoagulation may be driving it. It is not clear to us why people are having more diagnosis of brain injury."

Dr. Alan Woodward noted that the data on a death certificate is crude data, having filled out many death certificates himself as a physician – that one really has to go and look at the medical records to find the location of the fall and more comprehensive data on deaths can be found in the emergency department or hospital records. Dr. Hackman replied, "That may be our next step in surveillance, is to try to examine the autopsy findings in toxicology." Chair Auerbach added, "Let me just clarify why we haven't done that because It was the intention of the staff in Injury Prevention Surveillance to look as thoroughly as possible, but the amount of work that was involved in actually accessing the medical records is so significant that we just simply didn't have the personnel to be able to do that…If we are successful in terms of getting the additional resources, I think our intent is to begin to do some of the work that has been suggested by Members of the Council, and it really has just been limited by resources."

Alice Bonner, PhD., RN, Executive Director, Massachusetts Long Term Care Foundation, Assistant Professor, University of Massachusetts, Graduate School of Nursing, Worcester, addressed the Council. She presented data on nursing home falls. She said in part, "...Five years ago, we started doing programs for nursing homes. We in-serviced over a thousand nursing home employees, probably touching about 80% or 90% of the nursing homes in this state with various programs, whether it was our symposium in May, or the ongoing programs that we do. We do programs now almost every month and we sell out every month because people are so concerned about this problem, but rather than just do a single program, where we have people come in and give them education, we actually follow up with anyone who has been to one of our programs with some regular conference calls. It is like a collaborative model. So people have gotten the education and go back to their facility. They try things. They improve strategies. They work together, and if it doesn't work, they have an opportunity to get together with their colleagues, with calls that are moderated by someone like myself, or one of the other members of the Coalition, and talk about what worked, what didn't work, and get help from other people who have been successful. If there is a nursing home that has reduced their falls rate significantly and they are on the collaborative call, they can share

information. That we hope is having an impact. We have also brought in physicians, nurse practitioners, the Mass. Association of Health Plans, Dr. Riley at the Board of Registration in Medicine, so bringing everybody to the table. This isn't just a nursing issue. It is not just a nursing home issue. It involves everybody, patients, families and getting everyone involved…"

Dr. Bonner noted that the Fall Risk Assessment Form has been updated and is available on their web site. She noted that they provide consultation in person or on the telephone. She said, "Whether it is myself or one of the other people on the Coalition, who works in a nursing home, if we get a call they say our fall rates are too high. We think we have done everything. We don't know what else to do. Can you help us? We can either put that nursing home in touch with a nursing home that has a really comprehensive program that has worked well, or if they have an individual case, they can run the case by somebody who has got expertise in that area. We get a lot of calls about geriatric psych cases, for example, end stage dementia falls, hospice falls, and we can provide help that way. The other thing, is either myself or someone else can go out to the facility and look at what are the environmental risks? Is it a dim lighting issue? Is it something related to the physical environment or the environment of the staff because a lot of what we have been teaching is around patient safety culture, how people relate to each other, how they communicate about falls, and how they work as a team, or don't work as a team, and you can't get that from a piece of paper. You have to go there to see what is going on. You have to talk and listen to the staff, and we have been doing a lot of that through the Mass. Long Term Care Foundation."

In conclusion, Dr. Bonner said, "Our goals are not just to sustain this lower rate of falls with fractures, but to actually improve it. It still seems like there are a lot of fractures out there, and we know that rates are going to be much higher in nursing homes than in the general population, but we really feel that this shows we are on the right track. We have a lot more work to do, but we are going to continue the awareness raising campaign, continue to coordinate with our partners through the Care Transitions Group and the National Council on Aging and some other groups…"

Chair Auerbach asked for an example of a best practice nursing home. Dr. Bonner said in part, "It starts with leadership and then you have to go to the front line workers. When you have a group

of workers who come to hear about falls prevention, and there are no nursing assistants in that group, that is a problem. They don't understand, the nursing assistants are the ones right at the bedside. They are the ones who identify change in condition and can prevent that next fall. The homes that have been effective have brought the nursing assistants to the programs, so that the nursing assistants are very involved in falls prevention. They listen to the nursing assistants. They get information from them about what the nursing assistants think is going to prevent the next fall in Mr. Jones, and also what the nursing assistants think is going to prevent falls on the unit where they are, and then, in the whole facility. It's looking at individual patients, looking at the units; and then, looking at the entire facilities. Using better high tech alarms, silent alarms that register with the care provider so they can respond immediately, and identifying why the person is getting up instead of just putting an alarm on them. It is really getting people to communicate better and pass information better. The day shift is talking to the night shift. The homes that have done those things have shown an improvement, and they are feeding back data to their staff. It is not just the administrator saying, my fall rates is lower now. It's them saying to the CNAs on the unit, this is a terrific job you have done. Your fall rates are low this month, and let's talk about why this is. It is sharing data with people, so they understand."

Mr. Lewis Howe, Injury Prevention and Control Program DPH, addressed the Council. He said in part "...The Massachusetts Falls Prevention Coalition was formed less than two years ago; and yet, we already have almost sixty partners now, which is a testament to the energy and enthusiasm of my Co-Chair, Dr. Bonner, and also Pat Kelleher, who is the third founding partner. Now, what the Coalition was set-up to do, is to connect individuals in organizations who work on falls prevention across all sectors and continuum of care. That includes hospitals, skilled nursing facilities, home care agencies, clinics, universities, state and local governments, and pharmacists. We work with health care professionals, government officials, and consumers to develop and implement evidence-based programs to prevent falls in Massachusetts. In addition to the founding partners that I have mentioned, the Visiting Nurses have been extremely important to our effort; CMS, MassPro, the Mass Medical Society, the Brain Injury Association of Massachusetts, Commissioner Auerbach and Secretary Festa of Elder Affairs have been important partners in our effort..."

Mr. Howe noted further, "...The mission of our Coalition is to promote lifestyles, behaviors and strategies, to prevent falls and fall-related injuries, and also to maintain independence and autonomy among our seniors. We want to reduce, obviously, the incidence and severity of falls across the life span, with a special focus on older adults, and we promote collaboration, communication and training, so that information and best practices can be shared across the settings. We want to make sure that our older adults live longer, happier and healthier lives, as long as possible, and we are also devoted to cost containment, which of course is very important to all of you and all of us."

Mr. Howe noted some of their accomplishments: They held a symposium in concert with Mass. Extended Care Federation (MECF) in which 800 people attended and 200 had to be turned away, will hold one again in 2009; the "Patients First Initiative" with the Division of Health Safety and Quality; the long term care risk assessment tool available on line at www.mecf.org.; creation of falls awareness badges for Staff and Coalition partners; quarterly collaborative effort conference calls and group sessions and one thousand long term care staff members have been trained, Office of Healthy Aging has held Matter of Balance training sessions in 2008; and a social marketing campaign with assistance from Emerson College Graduate Program in Health Communication and with funding from Fallon and EverCare insurers."

In conclusion, Mr. Howe said, We have a strong, firm coalition and, from that, our next step, I am pleased to say, is that, as a follow-up to Carrie's report, we will be working on a fall strategic plan over the next eight to twelve months, which will draw from the work that has already been done by our community subcommittee, as well as our data subcommittee, which Holly chairs, our Committee on Long Term Care, and our hospital committee. We are really at the fledgling state and there is a lot more work to do as the Commissioner eluded to..."

Dr. Bonner noted, "...We would really like to develop a Falls Prevention web site. That is one of our goals. We are using space on the DPH web site now but many states have their own Fall Prevention web site. It has to be easy for people to find, and we could really put so much more on it. I think that is something we will be raising money for."

Council Member Albert Sherman, responded, “This hasn’t bubbled up to my office yet, but if you send me an email, I will see if I can get you some money for the web site.”

Dr. Bonner thanked Mr. Sherman and the Commissioner reminded him that it is now on the record. Discussion continued and Chair Auerbach stated, “One piece of additional work that is going on, the Council will hear about it in the coming months, that is the efforts to mandate that hospitals report serious reportable events to the Department for our public web site, including the most frequent of the serious reportable events is falls-related. We will be getting for the first time, very accurate information on fall-related serious injuries and deaths in hospital settings. We have preliminary information on that, that we will be able to share with you in a few months. And secondly, the Cost Containment Law includes a provision that the Council must pass a regulation which prohibits the billing of insurers for the medical costs associated with serious reportable events and, again, that covers fall-related injuries. I think that will be an effective preventive mechanism because it will provide additional incentives for hospitals that are already doing things to try to minimize falls, to put more resources into those efforts in order to avoid the very significant additional cost that will be associated with injuries that are no longer billable.”

Discussion followed, Council Member Mr. Albert Sherman questioned whether hospitals would comply with reporting the falls to the department. Chair Auerbach replied that people are forthcoming and risk the loss of their license is they do not report the information to the Department. Dr. Muriel Gillick, Council Member stated, “As a Geriatrician I am painfully aware of not only the monetary costs of falls, but the devastating consequences in terms of function and quality of life, and I think that the surveillance work that you have done and some of the prevention work you have done are outstanding, but I have to say, at the risk of putting a damper on all this enthusiasm, that I am a little concerned about the claim, for example on page 79 of the report, that most falls are preventable. I think we have, some of the best work that has been done has come out of Mary Tenetti’s group at Yale University, where she uses a multi-factorial approach, a multi-pronged approach and most of the prongs are what you have got on your yellow card, to try to decrease falls. But her work, the extent to which falls are decreased is a few percentage points. Now, this is statistically significant and it is clinically meaningful

and is, by no means something to be sneezed at, but I am a little concerned about statements that we can actually prevent all falls, and the reasons that I am worried about it, it's a laudable goal to improve our knowledge and to do a better job, but I think it is clear that many people decide to put someone in a nursing home as opposed to home because they think the nursing home will be one hundred percent safe, and as you have indicated, even with good programs in place, that is not going to be achievable, at least in the foreseeable future, and I think that, while patients and families have the right to expect that the nursing home will do what is reasonably available, to decrease the likelihood of falls, they are not going to eradicate falls. And I also don't, in a similar vein, not only do I not want to see people put in nursing homes because of the misplaced belief that that will be a perfectly safe environment, nor do I want patients and families getting furious at the nursing home providers, even when they are doing all the things that you are trying to encourage them to do."

Dr. Bonner responded, "Absolutely, and those are all great points, and to those points, when we have been working with the surveyors in the Department of Public Health, we have been sharing the same information so that, when they go into the nursing homes, we are all speaking the same message and that is, we want to identify what we think are the preventable falls, and differentiate those from falls that you can look at the record and see, there perhaps was nothing else that the nursing home could do to prevent a fall."

Dr. Bonner gave an example, "For someone who the family wanted them to be up and independent in the nursing home, and they had a gate disorder, and they had a certain number of medications, and so, to work with the surveyors, to help them to be able to say, there are some falls that perhaps could not be prevented, and also to work with families and patients around this issue. That is why Pat Kelleher's work with the Home Care people is so important. They are the ones who can help families understand, you know, your mother will not stop falling when you put her in a nursing home, necessarily; that is not what happens, because we know that those are the most frail patients with the most risk factors. So, I agree and I often will say, many falls are preventable, and I think that is perhaps the way to go because I do think many falls are preventable. I think the jury is out as far as whether it is most falls or not. I think you know, Mary Tennetti's study showed that it takes a great effort in

communities, and it takes a multi-pronged approach. You have got to get to the health care professionals, the physicians, nurses, rehab people, families, councils on aging, and senior centers. I mean you have just got to get everyone and really build a different infrastructure"

Dr. Gillick added, "If you do all that, you still don't eradicate falls, and the other piece to remember is that, there is also an issue of autonomy, that it might be that, if individuals exercised and used assistive devices, that they would be much less likely to fall, and it is certainly our obligation to try to educate people and persuade them that it is in their best interest to do those things, but there are lots of people who are 90 years old who say, 'I am sitting in my wheelchair and I am not going to get up and do your foolish exercise program.' We need to acknowledge that and recognize that, and it is our ethical obligation to make sure they understand the potential consequences of those decisions, but those are decisions that individuals make, and we are not always going to be able to change their minds."

Mr. Howe thanked Dr. Gillick for her remarks and said he should sign her up to be on the Coalition and further that he believed a good deal of falls and the resulting injuries that result from them can be prevented.

Chair Auerbach stated in summary, "I think your caution is a good one that we should be realistic about what the outcomes can be. I think this also arises when we have the discussion about serious reportable events, which sometimes get referred to as Never Events, some of which are, in fact, events we could paraphrase as Never, such as wrong site surgery; however, I think there is significant debate about whether falls should be characterized in the same way and should really be thought of as, in hospital settings, a hundred percent preventable, and that become a standard. I thank you for that dose of reality, in terms of what we can realistically expect, even from very impressive activities, which you described today. Let me just thank you all. I think you gave just a spectacular presentation, both on the extent of the problem, helping us to understand more what are some of the specific risks involved, where can we be effective in terms of our resources. We, I think the Council has suggested some places where additional research makes sense, and where we would like to see resources prioritized in the future, greatly appreciate the work that is being done by the Foundation and the Coalition..."

No vote/Information Only
INFORMATIONAL BRIEFING ON PROPOSED AMENDMENTS TO LOW-LEVEL RADIOACTIVE WASTE MANAGEMENT FUND REGULATIONS – (345 CMR 4.00):

Council Member Albert Sherman thanked Suzanne Condon, Director, Bureau of Environmental Health for her response to an environmental concern at the Newman School in Needham. He said she did a outstanding job and he thanks her personally and professionally.

Ms. Suzanne Condon responded, I will make sure our indoor air quality team hears what you had to say because they do an awful lot of work across the Commonwealth in schools everyday and the Newman School was a very difficult situation because of a range of problems, but they were able to work together with the local community and address all of those. She noted that the Director of the Radiation Control Program could not attend today. Also in attendance was Bob Gallagher, Assistant Director, Radiation Control Program, Will Sellers, Manager of the Radioactive Waste, Low Level Radioactive Waste Management Program and Attorney James Ballin, Deputy General Counsel, DPH.

Ms. Condon noted, "The purpose of us being here today is to discuss proposed fee increases associated with carrying out the Low Level Radioactive Waste Management Program. In brief, in 1987, the Legislature passed the Low Level Radioactive Waste Management Act, and that established a Low Level Radioactive Waste Management Board. Among things that the Board was charged with was the promulgation of regulations that would deal with waste management, the selection of operators for a waste disposal site in Massachusetts, and establishing a fund that would cover the cost of implementing the regulations themselves. In 1997, the Board abandoned the option of siting such a facility in the Commonwealth of Massachusetts, largely due to public concern that had been expressed across the Commonwealth. People supported the idea of having it, but no one necessarily wanted it in their community. And then in 2003, the powers and duties of the Board were transferred to the Department of Public Health and our Radiation Control Program. Among the other tasks that are carried out by staff, is the preparation of an Annual Report, which details the amount of waste generated in Massachusetts each year and one of our most important tasks right now is ensuring that we have disposal options going forward.

Some of you may have been hearing about this place called Yuka Mountain, and it has been stalled at the federal level, so the waste options that transferred to Yuka. That didn't happen, and when Barnwell closed their doors in South Carolina just this summer, we all had to scramble to find ways to wrestle with the management of radioactive waste...The work we do is largely funded by assessments to licensees who receive, possess, use, transfer or acquire radioactive materials in the Commonwealth. There are about five hundred licenses in total, and they range from a small, one-person operator, somebody who is, for example, a lead paint inspector, that might use an XRF machine to measure lead, the amount of a lead in a given home, up to industrial companies, hospitals, universities, research organizations and the like. Each assessment is calculated using a formula that is prescribed in the regulations, and it takes essentially takes waste class and total amount of radioactivity into consideration. The fee actually is composed of two parts. One is a flat fee that is paid by all licensees, and the second is a proportional amount that is based on the amount of waste produced by a given licensee. While most licensees pay just the flat fee, there are about a hundred and ten that pay a proportional fee in addition to the flat fee because they actually generate waste."

Ms. Condon continued, "In 2006, you may recall that the Yankee Row Nuclear Power Station, which generated over half of the Departments Low Level Waste Revenue, closed their doors. The loss of this single fee-payer resulted in expenditures at the program level exceeding our revenue by about a hundred and seventy-four thousand dollars. The proposed new fee structure would restore the revenue levels to a point that would be similar to former staffing levels, and would allow us to sustain the program...Basically, the proposed new fee structure would increase the flat fee to a hundred dollars per year for about 75 licensees and a 150 per year for about 315 licensees, and the remaining licensees would see a larger increase, as I said, depending up on the actual mix of the waste that they produce. The second part of the fee, called the Proportional Assessment, is based on a per cubic foot charge, and it is calculated in accordance with the formula found in the regulations. I should say that the amount of waste that is generated by the most serious radioactive waste in our State is about four hundred cubic feet per year, so just to give you kind of a sense that this isn't a huge amount of waste, but there are a lot of places that we have to monitor."

Ms. Condon said further, "In order to best prepare for our discussion with you, we did a survey of other states, and we are pretty much in the middle. Our fees are not going to be looked at as amongst the highest in the nation. They are reasonable, particularly for states that don't have a waste facility in their state, but the public has spoken years ago about this. These new fees would propose to be in effect for calendar year 2009. Following today's discussion, our hope is to move forward with public hearings and, after receipt of public comments, and response to public comments, our plan would be to return to the Council for approval of these regulatory amendments in November but it is looking more like December."

The Council asked a few brief questions on the reasonableness of the fees. Dr. Woodward stated, "the flat fee at $150.00, they would be paying less than they did at $75.00 in 1993 dollars. So, it is not an expanse that is out of line with inflation. I would think this is palatable for people who are managing that."

NO VOTE/INFORMATION ONLY

REQUEST FOR FINAL ADOPTION OF AMENDMENTS TO MINIMUM STANDARDS GOVERNING MEDICAL RECORDS AND THE CONDUCT OF PHYSICAL EXAMINATIONS IN CORRECTIONAL FACILITIES – 105 CMR 205.000:

Ms. Suzanne Condon, Director, Bureau of Environmental Health was accompanied by Attorney Sondra Korman, Deputy General Counsel, DPH and Attorney Korman presented the correctional facility regulations to the Council.

Attorney Korman noted and staff's memorandum to the Council explained, "We are here to request final adoption of amendments to the regulations governing the health screening of inmates within the Massachusetts correctional system, 105 CMR 205.000...At the May 14, 2008 Council Meeting, staff briefed the Council on a proposal to delete section 205.200(D) (3), the requirement that correctional facilities perform syphilis serology upon admission. At that meeting, the Council authorized the Department to proceed with the public comment process on the proposed amendment. The Council also voted to add the following underscored language to 105 CMR 205.200(D):

'Diagnostic tests: The following diagnostic tests shall be performed on each inmate consistent with the recommendation of the U.S. Preventive Services Task Force and as clinically appropriate.' "

Attorney Korman further noted, "The Department held a public hearing on June 18, 2008 for the purpose of receiving comments on the proposed amendments. Four persons attended the hearing. Peter Heffernan, Deputy Director for Health Services for the Department of Correction (DOC), provided oral testimony on behalf of the DOC and its contracted medical provider. The Department did not receive any other testimony at the hearing or any written comments on the proposed amendments. According to Mr. Heffernan, the DOC and its medical provider have no objection to deleting the requirement that syphilis serology be performed upon routine admission. As to the proposed amendment to 105 CMR 205.200(D), Mr. Heffernan suggested inserting, after the phrase 'as clinically appropriate', an explicit reference to the related regulatory section, 205.101[1] Section 205.101 describes specific procedures to be followed if the admitting inmate's medical record reflects that he/she has had a physical examination within the last three months. Mr. Heffernan also suggested amending 105 CMR 205.101(C) to add the term 'diagnostic' before 'tests'. Staff agrees and recommends adding the clarifying language suggested by Mr. Heffernan."

Attorney Korman stated, "I wanted to address some of the questions and issues raised by the Council in May regarding steps to assess the voluntary agreement of this patient population within the prison system to submit to these diagnostic tests and per vote of the Public Health Council, the public notice included this question and invited public comment. There were no written comments or oral testimony regarding this issue...but from discussions with Dr. Alfred DeMaria, Director, DPH's Bureau of Communicable Diseases and Peter Heffernin I can report back to you that The DOC's written Health Services policies incorporate and recognize, this as a settled legal principle, that all patients, including inmates within the correctional facility, have the right to refuse certain diagnostic tests or medical treatment, even life saving treatment. The written Health Services manuals include a refusal of treatment form, and encourage Health Services medical staff to do counseling and information gathering in terms of getting this inmate to consent to whatever medical procedure he is refusing. All inmates are

[1] 205.101: Inmates to Have Physical Examination

Each individual committed to a correctional facility for a term of 30 days or more shall receive a physical examination no later than 14 days after admission to said facility. However, an inmate entering a correctional facility who is accompanied by a medical record containing a record of a complete physical examination conducted less than three months prior to his admission need not be given a complete physical examination. Each such inmate not receiving a complete physical examination shall, however, be seen by a physician, or a physician's assistant or nurse practitioner under the supervisor of a physician who shall:

(A) Review the inmate's medical record.
(B) Examine the inmate for any signs of trauma disease which may have been incurred by the inmate after his most recent physical examination.
(C) Conduct any examinations and tests which are medically indicated.
(D) Review the findings and any required follow-up services with the inmate.

given orientation, both written and verbal, about the Health Services policies...A patient's right to refuse medical treatment is not absolute and that the State, the Massachusetts courts have recognized explicitly for inmates, that their right to refuse may be overwritten by the State's countervailing interests; for example, with respect to TB control, controlling the spread of infectious disease."

Attorney Korman noted that Dr. DeMaria couldn't be at the Council meeting but he wanted her to report to them his observations regarding DOC practices and procedures for individuals who may refuse treatment; that they are not punished or disciplined. In the case of infectious disease, the inmate is kept in the Health Services Division, the hospital unit until the infection is ruled out by the person agreeing to the test or through monitoring or chest x-rays. Dr. DeMaria wanted it noted that he sees the diagnostic tests as a good thing as it promotes public health and it is not used as punishment.

A brief discussion followed by the Council. Ms. Lucilia Prates Ramos inquired about who would testify at a public hearing. Attorney Korman noted per the regulations that notices are send to individuals who request a copy of the proposed changes; that it was posted on the DPH web site, and further that notices had been sent to the Inmate Advocacy Legal Office, the Mass Correctional Legal Services and other individuals. Ms. Suzanne Condon added that her hard working community sanitation staff person Steven Hughes corresponds regularly with prison staff, resolving various matters. He receives three to five letters per week from prison inmates.

After consideration, upon motion made and duly seconded, it was voted unanimously [Council Member Albert Sherman abstained] to approve the **Request for Final Adoption of Amendments to Minimum Standards Governing Medical Records and the Conduct of Physical Examinations in Correctional Facilities – 105 CMR 205.000.** A copy of the approved amendments are attached and made a part of this record as **Exhibit No. 14, 914**. This approval provides for adoption of these amendments as set forth in Attachment A:

1. Deletion of 105 CMR 205.200(D)(3): "Serology for Syphilis";
2. Adding the following underscored language to 105 CMR 205.200 (D):

   "Diagnostic tests: The following diagnostic tests shall be performed on each inmate consistent with the recommendations of the U.S. Preventive Services Task Force, and as clinically appropriate in accordance with the provisions of 105 CMR 205.101.

3. Adding the following underscored language to 105 CMR 205.101(C):

"(C) Conduct any examinations and diagnostic tests which are ~~medically~~ clinically indicated."

DETERMINATION OF NEED PROGRAM – REQUEST FOR APPROVAL OF INFORMATIONAL BULLETIN ON ANNUAL ADJUSTMENTS ON DETERMINATION OF NEED EXPENDITURE MINIMUMS:

Ms. Joan Gorga, Director, Determination of Need Program, presented the annual Bulletin to the Council for approval. She said, "I am here to request your adoption of the annual Informational Bulletin, which establishes the Determination of Need Expenditure Minimums. The minimums are increased each year through the use of two indices, Marshall & Swift Valuation Service for Capital Costs and Global Insight Health Care Cost Review for Operating Costs. Exhibit A shows the calculations used and Exhibit B shows the results, which will be used for the filing year, which began on October 1, 2008. As you can see from Exhibit A, the Capital Cost Index shows an increase of about 7.5 percent, and the Operating Cost Index shows an increase of about 3.75 percent. The results are shown in Exhibit B, for example, the Capital Expenditure in Acute care facilities, the expenditure minimum will increase from 14 million to 15 million. Projects with a dollar value below these minimums do not require the filing of a Determination of Need application. Staff asks that you adopt the Information Bulletin and the Expenditure Minimums for the next filing year."

Staff's memorandum to the Council, dated October 8, 2008, noted further, "These adjustments are being requested in compliance with M.G.L.c.111,§25B 1/2. These indices have been chosen by the Determination of Need Program as an authoritative resource due to their extensive use within the health care industry to determine inflation rates for a number of health care expenditures. While each of the indices has various regional and market sector subtleties and shadings, it is important for ease of administration to use a single inflation factor for capital costs and a single factor for operating costs. Thus, Marshall & Swift's statewide figures are used for the capital cost inflation and average of Global Insight hospital and nursing home figures is used as the basis for recalculating inflated operating costs. Historically, the Global Insight hospital operating costs have been based on a 1997 'market basket' of items as defined by the Centers for Medicare and Medicaid. This statistic will soon be phased out in favor of a 2002 'market basket' and so, starting this year, the Annual Adjustments for Operating Costs are based on the 2002 'market

basket'. The difference in the resulting calculations between the two indices is negligible, less than 1/1000th. The precise mechanisms for these calculations are set forth in Exhibit A. The newly calculated expenditure minimums are set forth in Exhibit B. These figures are effective October 1, 2008."

Mr. Albert Sherman moved approval. After consideration, upon motion made and duly seconded, it was voted (unanimously) to approve the **Informational Bulletin on Annual Adjustments on Determination of Need Expenditure Minimums, as noted below:**

EXHIBIT A

ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS:

Determination of Need Regulations 105 CMR 100.020 requires the Department of Public Health to adjust expenditure minimums (for inflation).

Capital Cost Indices (Marshall & Swift):

	October 2007	October 2008
Region – Eastern	2641.4	2840.0
Massachusetts	1.11	1.11

$$\frac{2840.0}{2641.4} \times \frac{1.11}{1.11} = 1.075$$

Operating Costs (Global Insight):

	4th Quarter 2007	4th Quarter 2008
Skilled Nursing Facility	1.128	1.164
Hospital	1.232	1.285

$$\left(\frac{1.164}{1.128} + \frac{1.285}{1.232}\right) / 2 = 1.0375$$

EXHIBIT B

ANNUAL ADJUSTMENTS TO DETERMINATION OF NEED EXPENDITURE MINIMUMS

CAPITAL EXPENDITURES

Project Type	October 1, 2007	Filing Year Beginning October 1, 2008
Equipment for non-acute care facilities and clinics	$760,442	$817,475
Total capital expenditure including equipment for non-acute care facilities and clinics	$1,520,886	$1,634,952
Capital expenditure, excluding major movable equipment, for acute care facilities and comprehensive cancer centers	$14,258,314	$15,327,687

Operating Costs

Project Type	October 1, 2007	Filing Year Beginning October 1, 2008
Nursing, Rest Homes and Clinics	$698,947	$725,158

FOLLOW-UP ACTION LIST:

- DoN Staff will send addendum to the August 13, 2008 Decision Letter to Northeast Hospital Corporation/Beverly Hospital (Project No.6-3B55) to remind them of their verbal agreement at said meeting that requires them to "provide in writing" to patients that free transportation is available for patients to their MRI facilities. [Joan Gorga]

- Perhaps take a longitudinal look at hospital discharge data to see how many falls are related to a readmission from a hospitalization stay within 30 days or 60 days prior (External Cause of Injury Codes). [Holly Hackman]

- Health Care Quality and Cost Council has a new work group on transitions in care and may be a good place for a pilot on medication reconciliation to try to get a reason for falls and why folks wind up back in the hospital. [Alice Bonner]

- If Department gets additional resources perhaps look at medical records in hospital or emergency departments for more comprehensive data on deaths and or autopsy findings in toxicology. [Holly Hackman]

- Council Member Sherman agreed to try to find funding for a Falls Prevention Web Site. [Sherman and Bonner]

The meeting adjourned at 11:10 a.m.

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John Auerbach, Chair

LMH